Mid-Valley Hospital

Mid-Valley Hospital
Mid-Valley Clinic

PO Box 793 - Omak, WA. 98841 www.mvhealth.org 509.826.1760

I AUTHORIZE THE RELEASE OF MEDICAL RECORDS KEPT FOR:

_____

Patient Address City/Zip Date of birth

TO BE RELEASED FROM:

_____

Institution/Doctor/Etc. Address City/Zip

AND SENT TO:

_____

Person Organization Address City/Zip

FOR THE PURPOSE OF: _____

THE RECORDS REQUESTED INCLUDE THE FOLLOWING:

- ☐ SUMMARY OF TREATMENT
- ☐ X-RAY REPORTS/FILMS
- ☐ LABORATORY TEST REPORTS
- ☐ ALL RECORDS
- ☐ MEDICAL HISTORY/PHYSICAL
- ☐ OTHER

FOR THE TIME PERIOD FROM: _____ **TO** _____

THIS CONSENT MAY BE REVOKED AT ANY TIME BY WRITTEN NOTICE AND EXPIRES 90 DAYS FROM THE DATE OF SIGNATURE.

_____ _____ _____

Patient/Legally Responsible Person Relationship Date

_____ _____

Witness to Signature Date

FEDERALLY PROTECTED INFORMATION

I specifically authorize the release of information pertaining to mental health, alcohol/drug use, sexually transmitted disease, or AIDS, diagnosis, and/or treatment, if such is part of the record. Redisclosure of such records is prohibited by federal law.

THIS INFORMATION IS RELEASED FOR THE PURPOSE OF:_____

_____ _____ _____

Patient/Legally Responsible Person Relationship Date

_____ _____

Witness to Signature Date

Date _____ copies made of (state name of form and how many of each): _____

Recipient _____ Personnel _____